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ABSTRACT

Geriatric day care which provides a continuum of care for the frail elderly is a relatively new type of service program, and client classification decisions are central to its implementation. Data on staff decision-making were obtained from clinical staff (N=7) of a state psychiatric center geriatric unit which offers programs at three levels of psychogeriatric day care (therapeutic day hospital, activities day care, community management). Clinicians ranked the importance of each of 20 variables in their decision-making process. Based on these ratings, the four most relevant variables were identified. Clinicians then considered each of these four variables in isolation and identified the programs in which they would place a person with a given degree of impairment in that area. Results revealed that the most relevant variables to placement decisions were severity of psychopathology, social isolation, activity level, and situation-emotional climate. Many factors cited as relevant also differentiated between participants in the three program levels. Clinicians reported using three of the four most relevant criteria in a way consistent with the program description and with client profiles. The social isolation variable, however, was applied inconsistently both with respect to the program descriptions and to client profiles. The findings provide support for subsequent program changes. (NRB)

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CLASSIFICATION DECISIONS WITHIN LEVELS OF PSYCHOGERIATRIC DAY CARE

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INTRODUCTION

Geriatric day care which provides a continuum of care is a relatively new type of program which has to date not been extensively studied, although a number of researchers have described such programs (Farndale, 1961; Pickett, 1979; Trager, 1976; Weiler and Rathbone-McCuan, 1978; and Pfeiffer, 1976). There have also been a number of attempts to evaluate day care programs for the elderly, both in terms of cost effectiveness (Weissert, 1978) and in terms of client outcomes (Rathbone-McCuan, 1973; State of Connecticut, Department of Aging, 1979; Weissert, Wan, Livieratos, 1980).

The present paper is an outgrowth of a project to study client outcomes in a program of psychogeriatric day care at a geriatric outpatient unit of a state psychiatric center. During the course of the study it became clear that an analysis of outcome by itself was incomplete; outcome was largely a function of process variables which required closer examination.

The importance of studying process variables has often been stressed (Weiss, 1972; Weiss and Rein, 1969). Such study is especially important in new or innovative programs where there is the greatest potential for "slippage between intent and action" (Weiss, 1972: 97).

One of the central process variables is the classification system used to match potential clients with the program. Johnson, Brown and Peterson (1980) attribute much of the confusion and difficulty in planning coordinated mental health services to the fact that different clinicians often use different criteria in placing clients. Classification decisions are, on the one hand, concrete expressions of clinicians' perceptions of the program and its goals.

On the other hand, these decisions directly influence the course of the program through the person/program matches which are achieved and the accommodations which must be made to serve the clients within the program.

Much has already been written regarding clinical decision-making and models which can describe, facilitate or replicate decision-making (Gauron and Dickinson, 1966; Roberts, 1978; Sherwood, 1975; Sherwood, Morris, Barnhart, 1975). Most recently Haddad (1981) outlined factors used by clinicians in placing psychogeriatric patients into skilled nursing, intermediate and psychiatric care. The present paper describes the classification process within three levels of a continuum of care psychogeriatric day program and relates this process to client profiles and to subsequent changes observed in the program. The three levels available within the Geriatric Unit program are: (1) therapeutic day hospital (DH); (2) activities and socialization day care (DC); (3) community management (CM) with access to DH and the facilities of the Geriatric Unit.

As reported more fully elsewhere (Frenkel, et al., 1980) the Geriatric Unit clients within the three programs were fairly homogeneous. Even those variables in which group differences occurred, the modal scores were very similar; differences among program participants were reflections of the presence of a number of exceptional cases. Overall, the participants did not represent a continuum of disability but rather those in each program had their own strengths and weaknesses.

Factors distinguishing participants in the three programs are: marital status, type of residence, social isolation, memory and orientation, severity of psychopathology, chronicity of psychopathology (as measured by history of institutionalization), activities of daily living, and activity level.

METHOD

Data on staff decision-making were obtained from clinical staff[1] of the Geriatric Unit through a two-stage questionnaire. At the first stage, clinicians were asked to rank the importance on a scale of 0 - 4 of each of 20 variables in their decision-making process. The variables to be ranked correspond to those examined in client assessment within the larger study. Based on these ratings, the four most relevant variables were identified. At the second stage, clinicians were asked to consider each of these four variables. Each variable was to be considered in isolation and clinicians were asked to identify the program in which they would place a person with a given degree of impairment in that area.

It should be noted that we recognize that decision-making is based on complex relationships among relevant factors and, in reality, no factor is considered in isolation. In fact, a number of clinicians expressed reservations about responding to our questionnaire because they could not judge the importance of any one factor without relating it to the others. It is with these same reservations that we present the following data. Recognizing that in examining variables in isolation we have created distinctions that are not present in the clinicians' day-to-day experience, we still feel that this reduction plays an important role in allowing us to examine the operation of the decision-making process.

[1] At the time of data collection professional staff was comprised of a clinical psychologist who served as the Unit Chief, 3 community mental health nurses, and 3 psychiatric social workers.

It should also be noted that the data reported here represent information obtained from within a single facility and from very few individuals. We have thus not attempted to make inferential statements but rather to use our findings to sensitize researchers and practitioners to the issues of classification decision-making.

In order to test whether clinicians do use the variables for placement that they claim, their assertions were compared to actual descriptions of clients in the three programs.

RESULTS OF CLINICIANS' RATINGS OF PLACEMENT CRITERIA

Most Relevant

As can be seen in Table 1, the two factors considered by clinicians to be most relevant to placement decisions are severity of psychopathology and social isolation. Both of these are rated either very relevant or relevant by all. The next most relevant factors cited are activity level and home situation-emotional climate. These are also rated relevant to very relevant by all clinicians. As can be seen, differences in the ratings of these variables are very slight.

Thus, as one would expect, there appears to be a high degree of correspondence between those variables which were cited as being important in placement and those which were found to differentiate among clients in the three programs. However, based on the information obtained from the second stage of the clinician survey, it was found that despite the correspondence on the variables used to classify clients, there are inconsistencies regarding how these variables are used.

Most clinicians would place clients with moderate to severe psychopathology in Day Hospital. This is consistent with the goals of the Day Hospital therapeutic program and with our finding that Day Hospital

clients exhibited the highest level of psychopathology. One clinician felt clients with the most severe level of pathology should be placed in Day Care. Another stated that she would differentiate between types rather than degrees of pathology with those having primarily functional disorders assigned to Day Hospital and those with organic disorders placed in Day Care.

The responses to the next variable, social isolation, were surprising. Four of the six clinicians said that in considering only social isolation, they would place those who are severely or moderately isolated in Day Hospital. This response was puzzling since it appears to contradict the stated purpose of the Day Care program, primarily a socialization and activities program. These results also are in contrast to our profile of participants, which describes Day Care clients as the most severely isolated. Only one clinician said he would place the severely isolated in Day Care. All clinicians felt that those with only mild isolation should be assigned to Community Management.

Responses with regard to activity level as a factor in classification were more consistent with our expectations - most clinicians stated they would place clients with low activity levels in Day Care, those with a moderate level in Day Hospital, and high level in Community Management. Our profile reflects slight differences across groups in this variable. These differences are consistent with the classification system described by the clinicians.

Turning to the next variable, most clinicians said they would classify clients residing in a home with a poor emotional climate into Day Hospital, those with a fair climate should be distributed into all three programs and those with a good climate would be referred to Community Management. The program description did not offer specific guidelines with regard to emotional environment, however, Community Management necessarily implies the

availability of a reasonably intact home environment. The participant profile did not reveal any difference among groups in response to the question "Are you having any serious problems with the people you live with?" However, a large number of Day Hospital clients were found to live alone, a condition which may be considered by clinicians to be a reflection of a poor emotional climate in the home.

Moderately Relevant

As shown in Table 1, two factors are rated slightly less relevant to classification than those discussed above. These are: activities of daily living and mental status. Group differences in these variables are evident in the participant profile with Day Care clients exhibiting the lowest level of each.

Least Relevant

Factors rated least relevant appear at the bottom of the table. Clients did not differ from group to group on most of these variables, thus providing some confirmation that clinicians did not in fact use these as criteria for placement. A number of exceptions, however, should be noted. Group differences were found with regard to four variables rated least relevant by clinicians: history of psychiatric treatment, prognosis, degree of drug compliance, and marital status.

The listing of the first of these, history of psychiatric treatment, as least relevant is most surprising, as the Day Care program was primarily designed for the long-term chronic psychiatric patient in contrast to the Day Hospital which was intended to serve those with acute problems. In fact, Day Care was comprised of those clients with the longest history of inpatient psychiatric treatment.

Slight group differences were found with regard to prognosis and degree of drug compliance, with Day Care clients having the least favorable prognosis and lowest level of compliance. Marital status was found to differ significantly among groups with Community Management having the highest proportion of married clients.

DISCUSSION AND IMPLICATIONS

In summary, our data suggest that the most relevant criteria for placement are: social isolation, severity of psychopathology, emotional climate of the home, and activity level. Clinicians say they use three of these criteria in a way consistent with the program description and consistent with our client profiles. The fourth variable, social isolation was applied inconsistently both with respect to the stated program description and our empirically derived client profile.

Moderately relevant criteria are activities of daily living and mental status and these were found to be different across groups.

Of the criteria judged to be least relevant, four were nevertheless found to yield group differences: history of psychiatric treatment, prognosis, degree of drug compliance, and marital status.

A number of possible explanations can be offered for our findings. First and most simply, some variables may have been understood differently by clinicians than we had intended. This would be particularly true, for example, of marital status. The phrase "marital status" may have been considered a demographic factor of little importance, while at the same time knowledge of the presence or absence of a spouse may be included in determining degree of social isolation, a highly relevant placement criterion. Such misunderstanding might also explain our finding regarding prognosis as Geriatric Unit prognoses often differ from those of outside physicians,[2] the survey did not distinguish between the two whereas the client profile utilized only Unit clinician prognosis.

[2] Information obtained from discussions at client review conferences.

A more fundamental explanation lies within the program's history and development, the details of which are reported elsewhere (Sherman, Newman, Frenkel, 1980). At the time of the study the Day Care program was in a state of flux. Although changes were primarily occurring within the Day Care program, all three programs within the Geriatric Unit form a closed system, and changes in any one cause a ripple effect and necessitate complementary changes in the other two.

The Day Care program was originally primarily an activities and socialization program intended for chronic psychiatric outpatients. However, clients with senile dementia were not excluded and administration and clinicians held differing opinions regarding their inclusion. Subsequently, the number of demented clients in Day Care increased. Once there was a "critical mass" of demented clients, accommodations had to be made to meet their needs and these accommodations fundamentally changed the nature of the program. In light of the changes, previous criteria for classification became less relevant and at the time of the clinician survey new criteria were in the process of evolving.

Thus, what appear to be inconsistent or contradictory criteria for placement may well be expressions of different perceptions of the program and the population to be served both currently and over time. These changes in the focus of the program can explain the surprisingly inconsistent results discussed earlier with regard to social isolation and history of psychiatric treatment. As Day Care became more of a respite and reality orientation program for the demented, Day Hospital became increasingly appropriate for isolated clients in need of social stimulation. Similarly, as the emphasis in Day Care shifted toward the more demented clients, history of psychiatric hospitalization declined in importance; chronicity of impairment was being replaced by organicity as a classification criterion.

The shift in emphasis was best expressed by the clinician who said she would classify clients on the basis of type of pathology rather than severity. It was the organic versus functional distinction which was becoming increasingly relevant to clinicians.

We can thus observe the pivotal role of placement criteria as they both reflect and implement the evolving goals and emphases of a continuum of care psychogeriatric day program. There is a dynamic relationship between program goals and criteria for placement; as the program evolves, the placement criteria of necessity also evolve and at the same time, the criteria themselves necessitate new program goals.

Table 1

FACTORS IN CLASSIFICATION DECISIONS

Factor	Range	Mean	Mode	Relation to Client Profiles
Most Relevant Factors - Included in second stage				
Severity of Psychopathology	3-4	3.7	4	Consistent
Social Isolation	3-4	3.7	4	Inconsistent
Activity Level	3-4	3.3	3	Consistent
Home Situation - Emotional Climate	3-4	3.3	3	Consistent
Moderately Relevant Factors				
Activities of Daily Living	2-4	3	3	Differentiates
Mental Status	2-4	3	3	Differentiates
Least Relevant Factors				
Psychiatric Diagnosis	1-4	2.9	3	Differentiates
Availability of Transportation	2-4	2.8	3	Differentiates
Feeling of Well-Being	1-4	2.6	3	Does Not Differentiate
Availability of Significant Others	0-4	2.4	3	Does Not Differentiate
Feelings of Mastery of the Environment	0-4	2.4	3	Does Not Differentiate
Level of Self Esteem	1-4	2.3	1,2,3	Does Not Differentiate
Health Status	2-3	2.3	2	Insufficient Data
History of Psychiatric Treatment	0-3	1.6	2	Differentiates
Prognosis	0-2	1.3	1,2	Differentiates
Degree of Drug Compliance	0-2	1.1	2	Differentiates
Socio-economic Status	0-2	1.0	0,2	Does Not Differentiate
Marital Status	0-2	0.7	0,1	Differentiates
Age	0-1	0.5	0,1	Does Not Differentiate
Sex	0-2	0.4	0	Does Not Differentiate

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